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Issue Date: 19 September 2007

CASE NO. 2004-BLA-6750

In the Matter of

H.W., .
Claimant,

v.

EASTERN ASSOCIATED COAL CORPORATION,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

William B. Talty, Esquire
For the Claimant

Paul E.. Frampton, Esquire
For the Employer

Before: Edward Terhune Miller
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

Statement of the Case

This case involves a request for modification of a subsequent claim for benefits filed by H.W., a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of

the Code of Federal Regulations.[1] Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by such pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease. Because the miner last worked as a coal miner for more than one year in the state of West Virginia, the claim is subject to the law of the United States Court of Appeals for the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-202 (1989) (en banc).

At the formal hearing on January 12, 2005, in Bluefield, West Virginia, all parties were afforded an opportunity to present evidence and argument as provided in the Act and the regulations, and the record was held open for the submission of evidence and post-hearing briefs. Following objections by the respective parties to the admissibility of the opposing party's evidence, an Order Regarding Admissibility of Evidence dated November 16, 2005, directed that the x-ray interpretations submitted as part of Employer's Exhibits 7, 8, 9 be stricken from the record; that the remaining documentation contained within Employer's Exhibits 7, 8, and 9 be admitted; that Director's Exhibit 51 and Claimant's Exhibit 3 be excluded. However, the pulmonary function and arterial blood gas studies in Director's Exhibit 51 dated May 23, 2002, do not exceed the evidentiary limitations set forth in §725.414, and upon reconsideration are admitted. Dr. Fino's report dated August 9, 2002, and, his interpretation of the chest x-ray dated May 23, 2002, contained in Director's Exhibit 51 are not admissible, because they exceed the evidentiary limitations in §725.414.[2] All other exhibits listed on Claimant's Evidence Summary Form and Employer's Evidence Summary Form are properly admitted into evidence.

The findings of fact and conclusions of law which follow are based upon appropriate analysis of the record, including all documentary evidence admitted into the record, testimony presented, and arguments made, as well as pertinent credibility determinations. Closing briefs submitted by the parties out of time have been considered in the absence of objection or a showing of prejudice.

Procedural History

Claimant, H.W., filed an initial application for Federal black lung benefits on June 1, 1983 (DX 1-1). A formal hearing was held before Administrative Law Judge Victor J. Chao on November 15, 1989 (DX 1-39). Subsequently, the claim was repeatedly denied (DX 1-44; DX 1-54), Claimant has filed multiple appeals and modification requests (DX 1-45; DX 1-55; DX 1-60), and the claim was still pending when Claimant requested permission to withdraw it by letter dated June 11, 1996 (DX 1). Pursuant to Claimant's request, and in the absence of any objection

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on February 5, 2001 (DX 3), the new applications are applicable (DX 101). All references to those regulations by section or part refer to Title 20, Code of Federal Regulations, unless otherwise indicated.

[2] The admission of parts of Director's Exhibit 51 are not outcome determinative, since the nonqualifying pulmonary function and arterial blood gas studies dated May 23, 2002, merely corroborate the other nonqualifying clinical tests in evidence (DX 52; *compare* DX 13; EX 10) The exclusion of parts of Director's Exhibit 51 does not affect the outcome of this decision, because Dr. Fino reached similar conclusions in a subsequent report dated November 19, 2004 (EX 10); and, the excluded positive x-ray reading of simple pneumoconiosis by Dr. Fino of the film dated May 23, 2002, is consistent with this tribunal's finding.

by Employer, Judge Samuel J. Smith issued an Order of Dismissal dated July 17, 1996, dismissing the claim pursuant to the provisions of §725.465 (DX 1).[3]

On February 24, 1999, Claimant filed an application for Federal black lung benefits which was denied by the District Director on June 2, 1999, because Claimant had not established any of the requisite elements of entitlement (DX 2). That denial became final. On February 5, 2001, Claimant filed this subsequent claim (DX 3). On September 24, 2002, the District Director issued a Proposed Decision and Order denying benefits because, although Claimant had established the existence of pneumoconiosis and its causation by coal mine employment, he had not proved that the disease had caused a totally disabling breathing impairment (DX 56). Claimant appealed, and on or about January 14, 2003, the claim was initially forwarded to the Office of Administrative Law Judges (DX 61, 67-70). Thereafter, Claimant moved to have the case remanded to the District Director for consideration of new evidence (DX 89). In the absence of objection Administrative Law Judge Linda S. Chapman remanded on October 21, 2003 (DX 90). The District Director treated the claim as a modification request under §725.310 (DX 92), and issued a Proposed Decision and Order on Remand – Denying Request for Modification dated June 7, 2004 (DX 94). After Claimant requested a formal hearing (DX 96), the claim was referred to the Office of Administrative Law Judges for *de novo* adjudication (DX 99-101).

Issues

I. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
II. Whether the miner's pneumoconiosis, if proved, arose out of coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability, if proved, is due to pneumoconiosis?
V. Whether the evidence establishes a change in conditions or a mistake in a determination of fact pursuant to 20 C.F.R. §725.310?
VI. Whether the evidence establishes a change in an applicable condition of entitlement pursuant to 20 CFR § 725.309?

(DX 99, as amended; TR 7-8).[4]

Findings of Fact

A. Coal Miner and Length of Coal Mine Employment

Claimant alleged 37 years of work in and around the coal mines ending on May 5, 1983, when there was a reduction in force and he was laid off (DX 3, 7; TR 7). The District Director found that Claimant proved 36.3 years of coal mine employment (DX 94). At the formal hearing, the Employer stipulated to at least 36 years of coal mine employment (TR 7). Accordingly, Claimant is credited with at least 36 years of coal mine employment.

[3] Claimant's testimony at the November 15, 1989, hearing before Judge Chao (DX 1-39) has been adopted for the current claim, subject to the supplemental testimony provided at the formal hearing on January 12, 2005 (TR 11-12).
[4] The Employer also preserved its challenge to the constitutionality of the new regulations as applied to this case for appellate purposes (TR 7).

B. Responsible Operator

Claimant's last coal mine employment of at least one calendar year was by the Employer, Eastern Associated Coal Corporation (DX 1-39, p. 14; DX 4, 7), which is properly designated as the responsible operator under the Act and Part 725, Subpart G.

C. Dependency

Claimant's wife, M.J.W., is his sole dependent for the purpose of augmentation of benefits under the Act. (DX 3, 10; TR 12).

D. Personal, Employment, and Smoking History

Claimant was born on August 24, 1926 (DX 3). At the hearing on November 15, 1989, Claimant testified that his last coal mine job was as a lampman. He had requested the position because he wanted to work in a less dusty area, and he had received a "Part 90 Miner Letter" indicating that he had black lung and was eligible for a job transfer. He worked in that position from November 3, 1975, to May 5, 1983 (TR 7; DX 1-39, p. 15). At the 1989 hearing, Claimant stated that his lampman job entailed repairing cap lights, calibrating methane spotters, cleaning the lamphouse, cleaning and sweeping the bathhouse, which included emptying trash cans, such as 55-gallon oil drums, rolling them 400 to 500 feet, putting them in pick up trucks, and hauling them to the dump. Claimant swept the floor using a push broom. He testified that there was some heavy work involved in carrying his naptha (DX 1-39, pp. 21-25), and that his prior jobs in the underground mines entailed heavy work in dusty conditions at the face of the mine (TR 15-19).

On the Description of Coal Mine Work and Other Employment form dated March 21, 2001, Claimant listed the Job Title of his last coal mine job as "Lamp Houseman" (DX 5), with a job description similar to that provided in his prior testimony. Claimant listed "Standing" as the only physical activity required by the coal mine job, but reiterated that he had switched to this job from prior jobs for health reasons, since he wanted to work in a less dusty environment (DX 5).

At the formal hearing on January 12, 2005, Claimant adopted his prior testimony, but added additional physical requirements regarding his work as an underground roof bolter (12-14). In his previous testimony, Claimant stated that he suffered from various breathing-related problems which limited his daily activities, and that he took various medications for his breathing and heart. The breathing medications included Organin, Lufyllin, and Ventolin spray. The heart medicine included Lanoxin and Coumadin. Claimant stated that he had never smoked (DX 1-39, pp. 34-38)

Claimant testified that he has changed treating physicians since the 1989 hearing; that Dr. Cardona is his regular physician; that Dr. Vardan is his cardiologist; that Dr. Lester sees him about once per year for a cancer checkup; and that "Dr. Ahnod" (sic) administered a CT scan in the course of the treatment by Dr. Lester (TR 13-15). Claimant considers Dr. Cardona and Dr.

Vardan to be his primary treating physicians for his breathing or lung problems (TR 15). Upon referral by Dr. Vardan Claimant underwent a heart catheterization by Dr. Frank England shortly before the January 12, 2005, hearing. (TR 16).

On July 12, 2005, Claimant testified at a telephonic deposition that none of his treating physicians have ever told him that he suffers from tuberculosis or histoplasmosis; that neither his wife nor any of his children have been diagnosed or treated for either tuberculosis or histoplasmosis; and that Dr. Cardona has treated him for breathing problems and arthritis, and provided him with three different inhalers. Claimant testified that he was last hospitalized for breathing problems in 1997, and that he has not lived or worked near chickens or other poultry (CX 19).

New Medical Evidence

The new medical evidence of record includes recent chest x-rays, pulmonary function studies, arterial blood gas studies, CT scan interpretations, and physicians' opinions which have been submitted since June 2, 1999, the date of the final denial of the most recent closed claim. (DX 2). The current claim was filed on February 5, 2001 (DX 5), and includes the request for modification under §725.310 (DX 89-94), subject to the evidentiary limitations in §725.414 (2006).

A. Chest X-rays

The record contains interpretations of chest x-rays, dated May 3, 2001 (DX 13, 35), May 23, 2002 (EX 3), April 8, 2004 (CX 2), November 5, 2004 (EX 6), and February 7, 2005 (CX 1, 4; EX 11, 16).[5] Four interpretations are positive for simple pneumoconiosis under §718.102(b): Dr. Patel's 1/2 reading of the May 3, 2001 x-ray; Dr. Ahmed's 1/2 reading of the April 8, 2004 x-ray (CX 2); Dr. Cappiello's 2/1, with Size A large opacities, reading of the February 7, 2005 x-ray (CX 1); and, Dr. Pathak's 2/2 reading of the February 7, 2005 x-ray (CX 4). Dr. Cappiello's finding of "A" large opacities would tend to support a finding of *complicated* pneumoconiosis under §718.304(a). Those physicians are both B-readers and board-certified radiologists. Five interpretations are negative for pneumoconiosis under §718.102(b): Dr. Wheeler's readings of the films dated May 3, 2001 (DX 35) and February 7, 2005 (EX 16);[6] Dr. Scatarige's reading of the May 23, 2002 x-ray (EX 3); and, Dr. Scott's readings of the x-rays dated November 5, 2004 (EX 6) and February 7, 2005 (EX 11). These physicians are also both B-readers and board-certified radiologists. Because the record contains multiple, conflicting x-ray interpretations by dually qualified readers, the x-ray evidence neither precludes nor establishes the presence of *simple* pneumoconiosis. The overwhelming preponderance of the x-ray evidence is negative for *complicated* pneumoconiosis. (CX 1, 4; EX 16, 11).

[5] The record contains hospitalization treatment records with descriptive interpretations by Dr. Aronson of chest x-rays conducted in conjunction with Claimant's hospitalization. They report various abnormal findings, but do not diagnose pneumoconiosis (CX 16), or expressly rule out pneumoconiosis. Neither the quality of the films nor the qualifications of Dr. Aronson are in evidence, and so these descriptive interpretations are accorded little weight.

[6] Dr. Wheeler did not report any profusion of small opacities on the May 3, 2001 x-ray (DX 35), but noted profusion "0/1" on the February 7, 2005 x-ray (EX 16). An 0/1 reading does not constitute evidence of pneumoconiosis under §718.102(b).

B. Biopsy Evidence

The Surgical Pathology report, issued by Dr. Soheila Yadrandji, relating to Claimant's lung biopsy at Montgomery Regional Hospital on March 18, 2005, provides a gross description and microscopic description, and indicates that the specimens consist of pleura right upper lobe, right upper lobe nodule, and a wedge portion of the lung. Areas of anthracosis were noted in the gross description. The microscopic description cited various abnormalities, including a calcified nodule, surrounded by anthracotic pigment, and a few noncalcified anthracotic granulomata. Dr. Yadrandji recorded a

FINAL DIAGNOSIS

1. Fibrovascular adipose tissue, consistent with adhesions – Pleura right upper lobe.

2. Calcified nodules, consistent with anthracotic granuloma x2, negative for acid fast bacilli and fungus – Right upper lobe nodule.

3. Pulmonary parenchyma, portions of, presenting anthracotic pigmentation. Anthracotic granuloma and mild emphysematous change, negative for acid fast bacilli and fungus – Right upper lobe nodule.

(CX 7; *See also,* CX 16, pp. 11-12; EX 18).

Dr. Soheila Yadrandji, who is board-certified in Anatomic and Clinical Pathology (CX 16), issued a supplemental report dated July 13, 2005 (CX 8) as follows:

> I am responding to your [Claimant counsel's] letter regarding [Claimant's] surgical case, S05-1276. In both gross examination and microscopic examination the lung parenchyma reveals at least two separate subpleural nodules measuring 0.3 cm to 0.5 cm. Each is partially calcified and shows the presence of anthracotic pigments and associated foreign body granulomas consistent with pneumoconiosis. Numerous, patchy, dark carbon particles are present within the pulmonary parenchyma. Special studies for Acid fast bacilli and Fungus are negative.
>
> In view of the patient's long history as an under ground miner, the findings are consistent with Coal Workers Pneumoconiosis. Recut sections also show one of the nodules to show evidence of trabecular bone and myelometaplasia. Numerous carbon pigments are engulfed by alveolar and interstitial macrophages. Evidence of Central Lobular Emphysema is also present.

(CX 8).

Dr. P. Raphael Caffrey, who is board-certified in Anatomical and Clinical Pathology, issued a consultation report dated June 25, 2005 (EX 13). Dr. Caffrey examined 17 surgical pathology slides in conjunction with the surgical pathology report and recorded the following microscopic findings and diagnoses:

MICROSCOPIC EXAMINATION:

According to the surgical pathology report #1 was a piece of pleura from the right upper lobe measuring 7x4x0.1 cm. Microscopically this tissue shows mostly fat and fibro-adipose tissue along with a number of small blood vessels. There is no inflammation, no nodules are noted, and no anthracotic pigment is identified. No granulomas are seen. The special stains for acid-fast and fungus are negative.

The second specimen according to the surgical pathology report was a wedge from the right upper lobe measuring 6x1.2x1 cm. Microscopically the tissue shows very mild centrilobular emphysema. There are lesions of simple coal worker's pneumoconiosis (CWP) present consisting of anthracotic pigment with reticulin and focal emphysema. There are two micronodules approximately 2 mm (0.2 cm) in size consisting of collagen and anthracotic pigment with focal calcification. No macronodules are identified. Special stains of acid-fast and fungus organisms are negative. The lesions of simple CWP occupy somewhere between ten and twenty percent (10-20%) of the lung tissue.

FINAL DIAGNOSES (17 surgical pathology slides labeled MRH-05-1276)

I. Tissue from right upper lobe of the lung including pleura
   a. Simple coal workers' pneumoconiosis, mild
   b. Centrilobular emphysema, mild
   c. Fibro-adipose tissue from right pleura – no diagnostic

(EX 13, pp. 1-2).

Because Dr. Yadrandji reported some anthracosis and findings consistent with coal worker's pneumoconiosis, and Dr. Caffrey unequivocally diagnosed mild, simple coal workers' pneumoconiosis, the biopsy evidence establishes the presence of *simple* pneumoconiosis.

C. Pulmonary Function Studies

To establish entitlement a claimant must prove that he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies. The record contains pulmonary function studies dated May 3, 2001 (DX 13), May 23, 2002 (DX 51), and November 5, 2004 (EX 10), none of which are qualifying under Part 718, Appendix B, even though Claimant reportedly gave less than maximum effort. Accordingly, the pulmonary function study evidence does not establish a totally disabling pulmonary or respiratory impairment.

D. Arterial Blood Gas Studies

Arterial blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen

tension either at rest or during exercise. The record includes arterial blood gas studies which were administered on May 3, 2001 (DX 13), May 23, 2002 (DX 51), and November 5, 2004 (EX 10). None of the studies at rest or with exercise are qualifying under Part 718, Appendix C. Accordingly, the arterial blood study evidence does not establish a totally disabling pulmonary or respiratory impairment.

E. Physicians' Opinions; Other Evidence[7]

CT Scans

The record contains CT scan interpretations (CX 1, 9-15; EX 1, 7, 8, 9, 12, 17), hospital and treatment records (CX 16), and the non-pathology medical opinions of Drs. Rasmussen (DX 13), Cardona (CX 5, 17), Vardan (CX 6, 18), Zaldivar (EX 5, 14), Branscomb (EX 2, 15), and Fino (EX 10). The record includes numerous interpretations of chest CT scans which were administered on August 21, 2001 (EX 1), November 6, 2001 (EX 1), November 4, 2002 (EX 1), September 18, 2003 (CX 13, 14, 15), February 25, 2004 (CX 11, 12), and January 26, 2005 (CX 1, 9, 10).

The earlier CT scans were interpreted as either negative for pneumoconiosis or as showing *simple* pneumoconiosis with coalescent opacities approaching 1 cm. Some of the interpretations of the more recent CT scans were also positive for *complicated* pneumoconiosis; other interpretations of the same recent CT scans were negative for pneumoconiosis.

These conflicting interpretations were rendered by similarly or dually qualified B-readers and board-certified radiologists. Accordingly, the CT scan evidence neither precludes nor establishes the presence of simple or complicated pneumoconiosis, although the biopsy evidence establishes the presence of *simple* pneumoconiosis. Greater weight may properly be accorded to pathology evidence than to x-ray and CT scan evidence, particularly if the radiological evidence is inconclusive, and the biopsy was conducted to clarify the radiological findings.

Treatment Records; Biopsy

The treatment records in evidence include Dr. Randall V. Lester's letter to Dr. Cardona dated February 14, 2005, which states, in pertinent part:

> [Claimant] has been followed for several years for multiple nodules in his lungs which have been felt to be related to pneumoconiosis. Recently, he has had an enlarging nodule in the right lung which has been evaluated by another radiologist and felt to be complicated pneumoconiosis. After reviewing the x-rays, I, too, feel that this is probably a benign lesion. However, because it has increased in size, one cannot be 100% sure

[7] Medical reports and physicians' testimony which refer to documents not admissible in evidence are deemed to have been redacted with respect to such inadmissible evidence. Unless there is a specific finding that the redacted data are critical to a physician's ultimate opinion, the redaction of objectionable information is deemed not to affect materially the weight properly accorded to the opinion. *See Harris v. Old Ben Coal Co.*, 23 BLR 1-98, BRB No. 04-0812 BLA (Jan. 27, 2006); *see also, Webber v. Peabody Coal Co.*, 23 BLR 1-123, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc).

without a biopsy. Therefore, I recommended a fluoroscopic biopsy if the patient is comfortable with that."

(CX 16). Shortly thereafter on March 18, 2005, Claimant underwent the biopsy which revealed evidence of *simple* pneumoconiosis (CX 16, pp. 11-12; EX 13, pp. 1-2). Accordingly, at issue is whether the other medical opinion evidence establishes the presence of *complicated* pneumoconiosis and whether such evidence establishes total disability due to simple pneumoconiosis.

Dr. Rasmussen

Dr. Donald L. Rasmussen is board-certified in Internal Medicine. Although he is not board-certified in Pulmonary Medicine, his curriculum vitae establishes that he has extensive experience in that field. Moreover, Dr. Rasmussen has testified on several occasions regarding coal worker's pneumoconiosis before subcommittees of the U.S. Senate and House of Representatives, and before the West Virginia Legislature (DX 13). Accordingly, Dr. Rasmussen's qualifications are deemed to be comparable to those of physicians who are board-certified pulmonary specialists.

On a U.S. Department of Labor form dated May 3, 2001, Dr. Rasmussen recorded Claimant's employment, family, medical, and social histories (DX 13, Secs. B & C); Claimant's complaints of sputum, wheezing, dyspnea, cough, chest pain, orthopnea, and paroxysmal nocturnal dyspnea (DX 13, Sec. D1); and on examination of the thorax and lungs, "normal" findings, with no rales, rhonchi, or wheezes. Dr. Rasmussen's examination of the heart revealed an irregular rhythm (DX 13, Sec. D4). He recorded the results of various clinical tests conducted on May 3, 2001, as follows:

Chest X-ray:	Pneumoconiosis t/q 1/2 all zones, coin density right upper zone.
Vent Study (PFS)	Normal.
Arterial Blood Gas	Normal.
Other:	SBDLCO minimally reduced.
Other:	Arial fibrillation by ECG.

(DX 13, Sec. D5).

Under the Cardiopulmonary Diagnosis section of the form report, Dr. Rasmussen set forth the following diagnoses and underlying rationale: "1. CWP – 37 years of coal mine employment and x-ray evidence of it. 2. Chronic bronchitis – Chronic productive cough. 3. Atrial fibrillation ? cause." (DX 13, Sec. D6). When asked the etiology of the cardiopulmonary diagnoses and to provide his rationale, Dr. Rasmussen stated: "1. CWP - Coal mine dust exposure. 2. Chronic bronchitis – Coal mine dust exposure. 3. Atrial fibrillation – non-occupational factor." (DX 13, Sec. D7). However, in response to the form question regarding the severity of Claimant's impairment and the extent to which the impairment prevents him from performing his last usual coal mine job, Dr. Rasmussen stated:

> The patient exhibits poor exercise tolerance, but has no significant loss of lung function. He retains the pulmonary capacity to perform his last regular coal mine job. He has atrial fibrillation which clearly limits his work capacity. The atrial fibrillation is not coal mine related.

(DX 13, Sec. D8a). In an accompanying narrative report dated June 28, 2001, Dr. Rasmussen essentially repeated the same data and conclusions as were set forth in the report for the U.S. Department of Labor (DX 13).

Dr. Cardona

Dr. Mario Cardona is board-eligible in Internal Medicine, and is approved by the Department of Labor for treatment of respiratory diseases (CX 17, Deposition Exhibit 4). Dr. Cardona testified that he is a specialist in internal medicine and disability evaluations for Social Security, coal worker's pneumoconiosis, and other work-related injuries (EX 17, p. 4). Dr. Cardona has been seeing Claimant since about 1990 (CX 5; CX 17, p. 6).

In a letter dated January 24, 2002 (CX 5), Dr. Cardona reported that Claimant has been short of breath with exertion for 25 to 30 years. Dr. Cardona reported "some deficiency" in pulmonary function studies, and "his chest x-ray shows coal worker's type of pneumoconiosis." Dr. Cardona also noted that a physician suspected cancer because of the advanced pulmonary fibrosis seen on a CT scan, but that he explained to the physician that Claimant has coal worker's pneumoconiosis. Accordingly, Dr. Cardona concluded: "A man with that finding, I believe, deserves to have compensation because of black lung." Dr. Cardona also stated that Claimant "comes to my office about every month, I treat him for several other conditions but I am in charge of giving him his respiratory therapy, pulmonary exercises, updraft nebulizations with Albuterol, Decadron, and normal saline sometimes with Atrovent and I advised him to use at home Combivent." In addition, Dr. Cardona opined that Claimant needs oxygen, and questioned the regulatory criteria regarding the arterial blood gas studies, stating:

> The point that I want to make clear is that I would love it if somebody really sees all the recommendation that [Claimant] has in his hands and really knows and decides that [Claimant] deserves to receive black lung benefits.

(CX 5).

In his deposition testimony on February 17, 2005, Dr. Cardona opined that Claimant has coal worker's pneumoconiosis based upon his long history of dust exposure in the coal mines, as well as his shortness of breath and other subjective complaints (CX 17, pp. 7-8). Dr. Cardona described Claimant's chest x-rays as "one of the most difficult" that he has ever encountered (CX 17, p. 8). Dr. Cardona also concluded that the most likely cause of Claimant's atrial fibrillation is a combination of coal worker's pneumoconiosis and age (CX 17, p. 15). In addition, Dr. Cardona stated that Claimant suffers from hypertensive cardiovascular disease, but not pulmonary hypertension (CX 17, p. 22). Furthermore, Dr. Cardona concluded that Claimant suffers from a pulmonary dysfunction. When asked to describe the dysfunction, Dr. Cardona cited shortness of breath on minimal exertion, episodes of paroxysmal cough, chest pains,

fibrosis of the lungs, and a 30 years plus of unprotected exposure in the mines. However, when asked whether any objective tests demonstrate a significant impairment, Dr. Cardona stated:

> Not in this case. As I stated previously, the pulmonary function test is normal, the blood gases are normal, but as a physician, I believe that this man just does have tremendous problems with the lungs.

(CX 17, p. 31).

Dr. Vardan

Dr. Sandeep Vardan, who is board-certified in Internal Medicine and board-eligible in Cardiology has treated Claimant since March 2001 (CX 18, pp. 3-4). Dr. Vardan issued a cursory, "To Whom It May Concern" report, dated September 12, 2002, (CX 6), the full text of which is as follows:

> The patient has significant coal workers pneumoconiosis resulting from chronic obstructive pulmonary disease. The result of his pulmonary limitation has contributed to his cardiovascular diseases. [Claimant] has atrial fibrillation, which has had some contribution from his pulmonary limitations. Atrial fibrillation requires multiple medications for treatment and unfortunately, due to his pulmonary disease, certain drugs of choice for heart rhythm and heart rate control may be precluded from use.
>
> Finally, Dr. Cardona has performed a reasonable assessment of [Claimant's] pulmonary disease in his January 24, 2002 letter.

(CX 6).

Dr. Vardan also testified at his deposition held on February 7, 2005 (CX 18), that "most likely the atrial fibrillation is related to his [Claimant's] lung disease." (CX 18, p. 10). However, Dr. Vardan primarily saw Claimant for cardiac-related conditions, and acknowledged that he never administered pulmonary function tests, including lung volumes, diffusing capacity, or blood gas tests, nor did he review such tests conducted by other physicians (CX 8, pp. 16-18). In addition, Dr. Vardan stated that he did not read any x-rays or CT scans, but simply reviewed some x-ray and CT scan reports (CX 18, p. 22). He also acknowledged that he is neither board-certified nor board-eligible in the fields of radiology or pulmonary diseases (CX 8, p. 12).

Dr. Zaldivar

Dr. George L. Zaldivar, a B-reader who is board-certified in Pulmonary Diseases, Internal Medicine, Sleep Disorder and Critical Care Medicine, who had previously examined the Claimant, issued a report dated March 13, 2003, in which he reviewed and analyzed available medical evidence (EX 5). Dr. Zaldivar noted that the chest x-ray and CT scan interpretations were conflicting, but

> Regardless of what the nature of the nodules are in the lungs, there is no question that the lungs are functioning normally. Therefore, even if pneumoconiosis is present radiographically, it has not resulted in any pulmonary impairment whatsoever.

(EX 5, p. 6). Dr. Zaldivar explained that, in the absence of severe airway obstruction and an accompanying increase in the pulmonary artery pressure due to chronic lack of oxygen, the atrial fibrillation is unrelated to lung disease. Dr. Zaldivar noted that there is no evidence of pulmonary hypertension, nor is there evidence of hypoxemia or airway obstruction. Thus, he concluded that the abnormal cardiac rhythm is a result of intrinsic cardiac disease unrelated to the lungs (EX 5, p. 5). Dr. Zaldivar opined:

> In conclusion, my opinion remains the same as given in the two previous occasions that I examined [Claimant]. [Claimant] has atrial fibrillation with poor exercise tolerance due to both deconditioning and reduced cardiac output due to the atrial fibrillation. [Claimant] does not have any pulmonary impairment whatsoever. From the pulmonary standpoint alone, [Claimant] is fully capable of performing not only his usual coal mining work that he performed prior to his retirement, but also, arduous manual labor if so were required. He has cardiac limitation as well as musculoskeletal limitation due to his age, but neither of these limitations are due to any pulmonary disease nor condition since none is present.
>
> The shortness of breath of which he complains is the result of both deconditioning and low cardiac output due to atrial fibrillation. The shortness of breath is not in any way related to his lungs which are functioning in a healthy manner. It is my opinion that [Claimant] does not need any other breathing medications which have been prescribed for him in the past. He needs exclusively the medication for the heart.

(EX 5, p. 6).

Dr. Zaldivar testified at his deposition on July 12, 2005 (EX 14), that he had reviewed additional medical data, including treating records, chest x-ray and CT scan interpretations, and biopsy analyses (EX 14, pp. 12-13). He cited Dr. Caffrey's biopsy finding of simple coal worker's pneumoconiosis, and noted that the enlarged nodule seen on biopsy and x-ray are granuloma which establish the presence of histoplasmosis (EX 14, pp. 21-24, 59-61). He noted that it is not unusual for someone to contract histoplasmosis without knowing it, since it is asymptomatic (EX 14, p. 17). Dr. Zaldivar reiterated that Claimant's "lung function is perfectly normal" (EX 14, p. 14), and testified that it is "nonsense" to suggest that Claimant could not take appropriate medications for treatment of atrial fibrillation because of his lungs. In so finding, Dr. Zaldivar cited Claimant's normal lung function and his ability to undergo a lung biopsy in March 2005, when he was nearly 80 years old (EX 14, pp. 30-32).

Dr. Branscomb

Dr. Ben V. Branscomb is a former B-reader who is board-certified in Internal Medicine. Although Dr. Branscomb is not board-certified in Pulmonary Medicine or Cardiology, his curriculum vitae and his deposition testimony establish that he has extensive professional and

academic experience in those fields (EX 2; EX 15, pp. 4-10). Accordingly, his qualifications are deemed to be comparable to those of physicians who are board-certified in those specialties.

Dr. Branscomb issued a report dated April 2, 2003, in which he reviewed available evidence (EX 2). He declared:

> **CONCLUSIONS:** I concur in the medical opinion that simple CWP is sometimes disabling, that CWP can be a progressive disorder first manifest after mining stops, that its manifestations may be latent, and that sometimes coal mine dust or CWP produce obstructive manifestations. I also incorporate in my definition of CWP for this report the concept that any pulmonary disorder or impairment in any way caused or significantly aggravated by either coal mine dust or CWP is regarded as pneumoconiosis. Further, I accept the concept that disability caused by a non-occupational disorder which has been materially worsened by either coal mine dust or CWP is included as a disability attributable, at least in part, to CWP.
>
> My conclusions which follow are made with a high level of medical certainty or probability with the exception that my diagnosis of CWP is somewhat presumptive since it is not clear whether the x-ray supports CWP in addition to granulomatous disease.
>
> My diagnosis is simple CWP caused by coal mine dust exposure. Based on the ongoing progress notes, hospital findings, and pulmonary function studies there is no reasonable confirmation that significant COPD is present. Pulmonary function is entirely normal. There is no impairment whatsoever caused or aggravated by [Claimant's] CWP, by coal mine dust, or by any other lung problem. He is impaired from work as a result of disorders entirely unrelated to the lungs or to coal mine dust exposure.

(EX 2).

Dr. Branscomb also testified at a deposition on July 12, 2005 (EX 15), that he had reviewed additional medical data, including depositions by Drs. Vardan and Cardona, pathology reports, and additional x-ray and CT scan interpretations (EX 15, pp. 11-12). He stated that the pathology evidence confirms his earlier opinion that Claimant has simple coal worker's pneumoconiosis, and opined that Claimant has the residual scars of granulomatous disease, and histoplasmosis (EX 15, pp. 12-17). Dr. Branscomb expressly declared that the evidence does not establish complicated pneumoconiosis, which is consistent with the biopsy results (EX 15, pp. 17-18). He discussed the development of histoplasmosis (EX 15, pp. 21-22), and reiterated that Claimant has no pulmonary or respiratory impairment, as shown on the objective clinical tests (EX 15, pp. 22-24). Finally, Dr. Branscomb rejected the suggestion that Claimant's atrial fibrillation is the result of lung disease, citing the absence of chronic cor pulmonale or right-sided heart disease or reduced pulmonary function (EX 15, pp. 24-27).

Dr. Fino

Dr. Gregory J. Fino, a B-reader who is board-certified in Internal Medicine and Pulmonary Disease, had previously examined Claimant, and in a report dated November 19,

2004 (EX 10), discussed the results of his more recent examination on November 5, 2004. He provided a detailed review and analysis of the available medical data. Dr. Fino set forth the patient's profile, occupational history, symptoms, past medical history, family history, review of systems, physical examination, and the results of various clinical tests, including chest x-ray, spirometry, lung volumes, diffusing capacity, oxygen saturation, carboxyhemoglobin level, and resting arterial blood gases. Having summarized other clinical findings, as well as the reported occupational and smoking histories, Dr. Fino recorded:

> **Diagnosis**
>
> Simple coal workers' pneumoconiosis.
>
> **Discussion**
>
> From a functional standpoint, this man's pulmonary system is normal. He retains the physiologic capacity from a respiratory standpoint to perform all of the requirements of his last job. This assumes that his last job required sustained heavy labor. My reasons are as follows:
>
> 1. There is no ventilatory impairment as the normal spirometry clearly shows no evidence of obstruction, restriction, or ventilatory impairment. This is based on review of previous pulmonary function studies, since the patient did not give a good effort during his most recent evaluation in my office.
>
> 2. The normal diffusing capacity rules out the presence of an impairment in oxygen transfer.
>
> 3. Arterial blood gases at rest and with exercise show no significant hypoxemia nor any evidence of a significant impairment in oxygen transfer that would prohibit this man from returning to his last mining job., In fact, his exercise oxygenation is normal. This is based on the normal room air arterial blood gases and the normal exercise study performed in 1999.
>
> **Conclusions**
>
> 1. Simple coal worker's pneumoconiosis is present.
>
> 2. There is no respiratory impairment present.
>
> 3. From a respiratory standpoint, this man is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort.

(EX 10, pp. 9-10).

Conclusions of Law and Discussion

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. The record contains multiple, conflicting interpretations of x-ray films by B-readers and board-certified radiologists. The x-ray evidence is inconclusive regarding the presence of *simple* pneumoconiosis; the overwhelming preponderance of the x-ray evidence is negative for *complicated* pneumoconiosis. Consequently, Claimant has not met his burden of establishing the presence of simple pneumoconiosis by a preponderance of the x-ray evidence pursuant to §718.202(a)(1), and has not established the presence of *complicated* pneumoconiosis under §718.304(a).

Under §718.202(a)(2) the biopsy evidence establishes the presence of *simple* pneumoconiosis, but does not establish the presence of *complicated* pneumoconiosis under §718.304(b).

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are applicable. The presumption under §718.304 does not apply because Dr. Cappiello's x-ray finding of *complicated* pneumoconiosis is outweighed by the clear preponderance of the x-ray evidence; the biopsy evidence only establishes *simple* pneumoconiosis; and, the preponderance of better reasoned and documented medical opinion evidence is negative for *complicated* pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Section 718.306 only applies to certain death claims filed by eligible survivors. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." §718.202(a)(1) and (2).

The CT scan evidence neither precludes nor establishes the presence of simple or complicated pneumoconiosis, although the vast majority of the physicians diagnosed varying degrees of pneumoconiosis, and the existence of simple pneumoconiosis is corroborated by the biopsy evidence. Accordingly, Claimant has established the presence of *simple* pneumoconiosis under §718.202(a)(4).

Since this case arises within the appellate jurisdiction of the United States Court of Appeals for the Fourth Circuit (DX 4), all the relevant evidence must be weighed together under §718.202(a) to determine whether the miner has pneumoconiosis. *See Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *see also, Penn Allegheny Coal Co. v. Williams*, 114 F. 3d 22 (3d Cir. 1997). The x-ray evidence is inconclusive, but the

preponderance of the biopsy and medical opinion evidence establishes the presence of simple pneumoconiosis. Therefore, pneumoconiosis has been established under. §718.202(a).

Causal Relationship

Since Claimant has established the presence of simple pneumoconiosis, he is entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. §718.203. This presumption has not been rebutted.

Total Disability

A claimant can establish total disability by proving that the miner has a pulmonary or respiratory impairment which, standing alone, prevents him from performing his usual coal mine work, and from engaging in gainful employment in the immediate area of his residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he previously engaged with some regularity over a substantial period of time. §718.204(b)(1). Since complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented him from engaging in his usual coal mine work or comparable employment. §718.204(b)(2)(i)-(iv).

None of the pulmonary function studies or arterial blood gas tests are qualifying under the applicable regulatory criteria in Part 718, Appendices B or C. The results of the valid clinical tests revealed little, if any, impairment. Therefore, total disability has not been established under §718.204(b)(1)(i) or §718.204(b)(1)(ii)

Although the record establishes that Claimant suffers from some heart-related problems, such as atrial fibrillation, there is no evidence that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, total disability has not been established under §718.204(b)(1)(iii).

> Finally, Claimant has not established the presence of a totally disabling pulmonary or respiratory impairment based upon the credible medical opinion evidence. The CT scan interpretations are inconclusive regarding the presence of simple or complicated pneumoconiosis. More significantly, CT scans, like chest x-rays, do not measure functional impairment. Consequently, the other medical opinion evidence, including the opinions of Drs. Rasmussen (DX 13), Cardona (CX 5, 17), Vardan (CX 6, 18), Zaldivar (EX 5, 14), Branscomb (EX 2, 15), and Fino (EX 10), is most probative, and has been qualitatively assessed by analyzing the credibility of each medical opinion considered as a whole, in light of that physician's credentials, documentation, and reasoning.
>
> Since the presence of *complicated* pneumoconiosis has not been established under §718.304, the medical opinion evidence overwhelmingly establishes that Claimant is not totally disabled by his simple pneumoconiosis or by any other pulmonary or respiratory

condition. The opinions of Drs. Rasmussen, Zaldivar, Branscomb, and Fino are more persuasive in this regard than the opinions of Drs. Cardona and Vardan. Although Drs. Cardona and Vardan have treated Claimant for many years, their pulmonary credentials are less impressive than those of Drs. Rasmussen, Zaldivar, Branscomb, and Fino. Moreover, the opinions of Drs. Rasmussen, Zaldivar, Branscomb, and Fino are much better reasoned and documented and are more obviously consistent with the objective clinical tests which establish that Claimant does not suffer from a significant pulmonary or respiratory impairment, as demonstrated by the pulmonary function studies and arterial blood gas tests which measure functional capacity. Therefore, Claimant has not established the presence of a totally disabling pulmonary or respiratory impairment under §718.204(b)(1)(iv), or otherwise.

Total Disability Due to Pneumoconiosis

Since Claimant has not established that he suffers from a total pulmonary or respiratory disability, he has also failed to establish total disability due to pneumoconiosis, as defined in §718.204(c).

Conclusion

Claimant has established evidence of simple pneumoconiosis arising out of his more than 36 years of coal mine employment. This proof establishes a material change in conditions or a change in an applicable condition of entitlement under §725.309 with respect to the final denial in 1999 (DX 2 – *See* Denial letter dated 6/2/99). However, these findings do not establish grounds for modification under §725.310, because the District Director's premodification denial recognized the existence of pneumoconiosis and its cause by coal mine employment, and was based, instead, upon Claimant's failure to prove a totally disabling pulmonary impairment (DX 55 – *See* Proposed Decision and Order dated 9/24/02). Accordingly, the District Director properly denied Claimant's modification request because Claimant had established neither a change in conditions nor a mistake in a determination of fact in relation to the District Director's earlier denial (DX 94 - *See* Proposed Decision and Order on Remand dated 6/7/04) It follows that Claimant has not established that he suffers from a total pulmonary or respiratory disability, or that he is totally disabled due to pneumoconiosis, and so is not entitled to benefits under the Act and regulations.

ORDER

The claim of H.W. for benefits under the Black Lung Benefits Act is denied**.**

A

Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).